California Medical Association

Council Highlights

Highlights of the Actions of the California Medical Association 545th Council Meeting, June 14 to 15, 1968, San Francisco

This summary is published so that CMA membership may be advised in brief of the actions of the Association's Council. It covers only major actions and is not intended as a detailed report. Full minutes of these meetings are available upon any member's request to the CMA Headquarters office.

CMA Activity in State Public Health matters was affirmed by Council when after discussion and amendment the following actions were taken pursuant to written recommendations presented by Dr. Carl Anderson:

- Voted to reaffirm the policy position that physician and county society involvement and participation in the "Partnership in Health" activities at the local level is of the utmost importance.
- Voted to adopt a policy statement that the public health of the people of California is a primary and continuing concern of the CMA and the physicians of California and to continue to implement this policy by seeking appointment of knowledgeable physicians on governmental boards, commissions and committees dealing with health and related problems.
- Voted to request California Blue Shield to explore the feasibility of serving as fiscal agent or on a prepaid basis for the administration of the Crippled Children's Services and other state administered medical care programs and sponsor appropriate implementing legislation if such a proposal is found to be feasible.
- Voted to encourage the Office of Health Care Services to establish and use a medical advisory

committee to guide the office in the day-to-day administration of utlization controls, prior authorization, county consultant activities and related activities.

• Voted to adopt a policy position that schools of public health should be closely integrated with schools of medicine and the allied health professions, and to encourage the Scientific Board and the deans of the schools involved to strive for such an integration.

• Voted to charge the Committee on Welfare Medical Care Programs with the responsibility of investigating the mechanism by which individuals are certified on the aid to the totally disabled program including the criteria for eligibility and the physicians who certify to such eligibility.

Legislative Activity Status report concerning state legislative bills on which the Council had taken a position was presented by Committee on Legislation chairman Dr. Dan Kilroy. Council direction was sought on the following currently pending bills with subsequent action noted: Voted to support S.B. 290 (allowing a person to will any part of his body for transplant purposes); voted to support S.B. 1245 (donation of blood by persons 18 years or older); voted to oppose A.B. 1837 (local school districts entering into contracts with neighborhood health clinics); voted to support S.B. 935 with proper amendments (Advisory Board on Radiation); and voted to oppose A.B. 633 (radiation).

Professional Liability activities were discussed by CMA legal counsel Howard Hassard with details on the current status of the six CMA-sponsored bills pending in the state legislature. Mr. Hassard stressed the importance of the introduction of the bills regardless of their fate this session. He emphasized that gains have been made in drawing the attention of the legislators to this problem area. In another portion of the report, Mr. Hassard suggested that CMA make a thorough study of the entire subject of experimental or investigational procedures in the light of professional liability. Council voted to request the Medical Review and Advisory Committee to study the problem of experimental procedures in consultation with the Judicial Commission and Scientific Board.

Utilization Plan for Hospitals under Medi-Cal was discussed when a joint CMA-CHA proposal was presented regarding a system for more effective utilization of hospital services. This proposal for recommendation to the Office of Health Care Services was approved by Council with amendment to provide for the involvement of California Blue Shield and county society review committees when physicians and other non-institutional providers were involved.

Medical Student Attitudes were approved by Council as the subject of a CMA survey under the auspices of the Committee on the Role of Medicine in Society. Objectives of the survey as outlined are: (1) to examine the attitudes of students and physicians in California in various phases of education and training to discover how such opinions vary among different groups and (2) to use the data as a base for a follow-up study to be conducted three years hence among the same sample population.

1968-69 Bureau of Research and Planning program objectives were approved with minor amendment on 13 projects presented to Council as follows: (1) California Physician Fee Index; (2) California Blue Shield Usual Charge Index; (3) Continuing Medical Education; (4) Current Medical Practice in Fee Determinations; (5) Group Practice; (6) Cost per Illness and Outcome; (7) Systems Analysis and the Physician's Practice; (8) Consumer Desires and Satisfactions with Health Care Coverage; (9) Socio-Economic Report; (10) Business Aspects of Medical Practice; (11) Medical Expert Panels in Malpractice; (12) Distribution and Characteristics of Hospital Emergency Medical Care Units; and (13) Physician Manpower: Supply and Distribution.

Multiphasic Screening Programs were discussed in a report by Dr. Marvin Shapiro who presented an itinerary for multiphasic screening of cannery workers during the summer and details of last year's multiphasic screening programs. In addition Dr. Shapiro presented several recommendations and the Council voted to approve the following criteria for multiphasic screening programs: (a) that the quality of these programs be upgraded; (b) that careful consideration be given to laboratory facilities in view of quality and cost; and (c) that clinical laboratories working with these programs be involved in a proficiency testing program.

Council also voted to adopt the policy that CMA consider multiphasic screening programs experimental in nature—and further that Council approves CMA's cooperation with organizations offering these programs (when invited) and to urge component medical societies to cooperate, particularly in patient follow-up (after evaluating the specific program and determining the effect of such cooperation).

Rural Health Manpower was the subject of a written and oral report which was based on the CMA Conference on Rural Health Manpower conducted last fall. Specific recommendations as approved by Council were:

• Voted to offer continuing education for rural practitioners in a format that will make it more available and meaningful to them.

• Voted to establish preceptorship programs that will adequately expose health science students to community needs; that include activities that will attract health science candidates from rural areas; that provide adequate faculty in

schools and community; that create involvement in rural community structure; that adequately finance the student and his family.

- Voted to institute a professional education program based on the health team concept and have this concept incorporated in the teaching and training by health science schools.
- Voted to actively involve medical students in the activities of CMA.
- Voted to develop new models for health care coverage and the delivery of health services in rural areas.

Bureau of Emergency Health Services of the State Department of Public Health was recently cut in budget, according to a report presented by Dr. Marvin Shapiro. Dr. Shapiro stated that the activities of this bureau are necessary to meet the provisions of the National Highway Safety Act. Council voted to approve CMA's appealing to the proper state official to effect a contract between the transportation agency and the SDPH, enabling the Bureau of Emergency Health Services to meet the National Highway Safety criteria for: emergency health services activity; driver licensing; and alcohol and driving study. In related actions, Council also approved the following items:

- Voted to request the Committee on Allied Health Personnel to compile a list of schools and courses for training emergency health care personnel in California.
- Voted to accept an invitation to cooperate in a symposium entitled "The Initial Emergency Care and Transportation of the Sick and Injured" to be conducted in September.

1968-69 Commission on Medical Services proposed objectives were approved by Council to include the following proposed projects: (1) Maintenance of Relative Value Studies; (2) Components of Adequate Health Care Coverage; (3) Non-Group Enrollment on a Pooled Basis for the Uninsured Population; (4) Group Practice; (5) Feasibility Proposal for Private, Plus Tax-Incentive System of Health Care for Under-Age 65 Population; (6) Resolution of Diverse Problems Reported to Affect Adversely the Physician's Professional Role in the Care of Patients; and (7) Compilation and Publication of Component Medical Society Grievance Committee Procedures.

Inhalation Therapy

A Joint Statement by the California Medical Association, the California Nurses' Association and the California Hospital Association

INHALATION THERAPY programs are becoming increasingly a part of patient care in hospitals. The organization for delivering such services to patients in hospitals varies. The administration of such a program in some hospitals is under the department of anesthesiology; in others, the pulmonary department or the nursing service, or other administrative structures. It is recommended the program be under the supervision of a qualified physician of the active medical staff.

Irrespective of the administrative structure, patient safety and sound overall patient care require an understanding, and implementation of the following:

Inhalation therapy is a part of total patient care. The overall supervision and the ultimate responsibility for the patient's plan of medical care is that of the attending physician. Therefore, it is the physician who will prescribe specific inhalation therapy based on the purposes to be accomplished by such treatment. All registered nurses should know inhalation therapy techniques and principles and their relationship to the total nursing care of the patient.

Inhalation therapists, inhalation therapy technicians, registered nurses, and other appropriately prepared personnel may administer inhalation therapy provided:

(a) Those performing inhalation therapy (inhalation therapists, inhalation therapy technicians, registered nurses, or other appropriately prepared personnel) shall be required to demonstrate satisfactorily:

1) The ability to operate the necessary equipment, and
2) Knowledge of the dosage and effect of any solution or medication used in inhalation therapy.

(b) There is communication and joint planning between the registered nurse responsible for the patient's total nursing care and the inhalation therapist, technician, or other person before, during, and after treatment. This is essential in order to assure safety and the most therapeutic results of overall patient care.

(c) Within each agency there are written policies relative to paragraphs (a) and (b) above and such policies are available to all involved in the patient's care. These policies shall be established jointly by representatives of hospital administration, the medical, nursing, and inhalation therapy staff.

June 15, 1968